Instructions and Checklist

- ☐ Complete and sign all designated areas
- ☐ Complete and sign the consent to release information
- ☐ A complete psychosocial history and psychiatric assessment including the Severe Mental Illness diagnosis completed **within the past year** must be included

Please use the Livingston County SPOA referral if the adult client:

- Needs Case Management and **does not** have Medicaid
- Needs supported housing (community residences and treatment apartment programs are not available in Livingston County)
- Has "difficult to serve" challenges that the SPOA committee can help to navigate as a referral source for the client

Please be aware that if the client has Medicaid and is in need of care management services, a HHUNY referral must be completed instead and sent directly to HHUNY.

SPOA referral **cannot** be used for Case Management for Medicaid/ Medicaid Managed Care Recipients.

Mail, email, or fax completed referral packet to:

Amber Hainey, SPOA Coordinator
Livingston County Mental Health
4600 Millennium Drive
Geneseo, NY 14454
Secure email:
amhainey@co.livingston.ny.us
Phone: 585-243-7250
Secure Fax: 585-243-7264

Criteria for Severe and Persistent Mental Illness (SPMI) Among Adults

To be considered an adult with SPMI, A must be met. In addition, B, C, or D must be met.

A. Designated Mental Illness Diagnosis

__YES __NO The individual is 18 years of age or older and has a primary DSM-TR psychiatric diagnosis **other than the following**: alcohol or drug disorders, developmental disabilities, dementias, mental disorders due to general medical conditions except those with predominant psychiatric features, or social conditions. DSM-IV categories and codes that do not have an equivalent in ICD-9-CM are not included as designated mental illness diagnosis.

AND

B. SSI or SSDI Enrollment due to Mental Illness

__YES __NO The individual is currently enrolled in SSI or SSD due to a designated mental illness

OR

C. Extended Impairment in Functioning due to Mental Illness

The individual must meet 1 or 2 below:

1. The individual has experienced *two of the following four* functional limitations *due to a designated mental* illness *over the past 12 months* on a continuous or intermittent basis:

__ YES __NO a. Marked difficulties in self-care
__ YES __NO b. Marked restriction of activities of daily living
__ YES __NO c. Marked difficulties in maintaining social functioning
__ YES __NO d. Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner at work, home, or school settings

2. The individual has met criteria for a rating of 50 or less on the Global Assessment of Functioning Scale.

__ YES __NO

OR

D. Reliance on Psychiatric Treatment, Rehabilitation, and Supports

__ YES __NO A documented history shows that the individual, at some prior time, met the threshold for C (above) but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitation imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supported settings which may greatly reduce the demands placed on the individual and thereby minimize overt symptoms and signs of underlying mental disorder.

Form completed by:

_____ _____

Signature **Date**

Livingston County
Adult SPOA Referral Packet

Referred By _____
Date _____

Programs Requested:

__ Supported Housing, is there a preference of:
[ ] Lakeview- Provides rental stipend Client must sign own lease for an apartment. Available on the open rental market. Staff is located in Geneva, so there is minimum in-person contact (usually once a month).
[ ] Arbor Development- Same as Lakeview, except the office is located in Dansville.
[ ] SkyBird Landing- Located in Geneseo, 30 apartments are SP SRO for homeless/ pending homeless individuals. The staff office is on site during business hours with basic case management services provided.

__ Non-Medicaid Case Management (If client has Medicaid, please refer them to HHUNY)
__ Other:

Client Name: _____ **DOB:** _____
Home Address: _____ **Age:** _____ **Gender: __M __F**
_____ **Social Security Number:** _____
Telephone Number: _____ **Insurance Name:** _____
Email: _____ **Insurance ID:** _____

Referral Agency: _____ **Address:** _____
Telephone Number: _____ **Contact Person:** _____

Mental Health Provider Name and Phone #: _____
Substance Abuse Provider Name and Phone #: _____
Case Manager Name and Phone #: _____

Person to Notify In Case of Emergency: _____
Name: _____
Address: _____
_____
Telephone: _____

Primary Care Physician: _____
Name: _____
Address: _____
_____
Telephone: _____

Client's Mental Health Diagnosis: _____

Client's Substance Abuse Diagnosis: _____

Please list any physical health issues client has: _____

COMPLETE IF HOUSING IS NEEDED

If SH is needed, is the client homeless?: __YES __NO

[ ] Homeless (street) [ ] Emergency Housing/Shelter

[ ] In respite apartment [ ] Temporarily staying with friends/relatives

[ ] In eviction process Explain circumstances: _____

If not homeless, what is the living situation?

[ ] Lives with parents [ ] Lives with other relatives [ ] Psychiatric center

[ ] Lives with spouse [ ] Assisted/supported living [ ] Correctional facility

[ ] Supervised living [ ] Nursing home/medical setting [ ] Other: _____

What does the client need from SH provider?

[ ] Client needs to find an apartment and needs a stipent to afford it [ ] Furniture

[ ] Client wants to stay in current residence and needs stipend to afford it [ ] Help with cooking

[ ] Medical supervision [ ] Getting to appointments [ ] Help with cleaning

[ ] Help budgeting money [ ] Help managing symptoms

Who will be in the apartment other than the client?

[ ] No one [ ] Pets (what type?) _____ [ ] Significant other

[ ] Children [ ] Other _____

Cultural issues that may impact treatment and treatment planning: _____

Ethnicity

[ ] White [ ] Latino/Hispanic [ ] Black (non-Hispanic)

[ ] Asian/Asian American [ ] Pacific Islander [ ] Native American

[ ] Other or dual (specify): _____

Current Education Level:

[ ] Some grade school 1-8th grade [ ] some HS 9-12th grade, but no diploma [ ] HS Grad

[ ] GED [ ] Some college, no degree [ ] Undergraduate degree [ ] Masters degree

[ ] Not graded [ ] Vocational, buiness traning [ ] No formal education [ ] Other: _____

Current Employment Status:

[ ] Employed full-time [ ] Employed part-time [ ] Unemployed

[ ] Training program [ ] Other: _____

Current Criminal Justice Status:

[ ] None [ ] Currently incarcerated [ ] Alternatives to incarceration [ ] CPL 330.20

[ ] Parole [ ] Probation [ ] Treatment Court [ ] Released from jail/prison in the last 30 days

[ ] Other: _____ Contact:

Probation or Parole Officer: _____ Phone: _____

Primary Language:

[ ] English [ ] Other: _____

English Proficiency: (if primary language is other than English)

[ ] Does not speak English [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Current Marital Status:

[ ] Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

[ ] Living with significant other/domestic partner

Custody Status of Children: (check all that apply)

[ ] No children [ ] Have children all > 18 years old [ ] Minor children currently in client's custody

[ ] Minor children not in client's custody with access [ ] Minor children not in client's custody- no access

Does the client have a history of any of the following?			**If Yes, Dates**
Fire Setting	[ ] Yes	[ ] No	_____
Sexual offense	[ ] Yes	[ ] No	_____
Violent acts causing injury or using weapons	[ ] Yes	[ ] No	_____
Aggressive/assaultive behavior	[ ] Yes	[ ] No	_____
Suicidal ideation	[ ] Yes	[ ] No	_____
Self-abuse/injury	[ ] Yes	[ ] No	_____
Suicide attempts/gestures	[ ] Yes	[ ] No	_____
Destruction of property	[ ] Yes	[ ] No	_____
Victim of physical abuse	[ ] Yes	[ ] No	_____
Attempted homicide	[ ] Yes	[ ] No	_____
Criminal arrests	[ ] Yes	[ ] No	_____

If you answered yes to any of the above, please describe the circumstances and method: _____

_____

_____

Is the applicant subject to a current order of protection? [ ] Yes [ ] No

Does the client own guns? [ ] Yes [ ] No

Is the client a registered sex offender? [ ] Yes [ ] No

Is the client a veteran? [ ] Yes [ ] No

Any other information that is important to share**:** _____

_____

_____

FUNDING APPLICATION FORM

Client Name:

	Case #	County	Currently Receives (Y/N	Amount Received (#)	Pending Application Submitted (Y/N)	Unknown
Social Security						
SSI						
SSD						
Public Assistance						
Veteran's Benefits						
Food Stamps						
Pension						
Wages Earned/ Income						
Unemployment						
Other						

Signature of person completing this form: _____

Print Name: _____ Relation to Client: _____

Release of Information

I, _____ hereby authorize the release of information to or by the Livingston County Single Point of Access Committee for the purpose of service coordination. This information will be used to arrange needed services. I understand that the release will allow information to be presented to the Committee at an initial review and at needed intervals. Participants in this Committee are listed below. I understand that all Committee members present will share information that pertains to developing the best possible plan for me.

I understand that this authorization covers only information required to arrange services and that the Single Point of Access Committee will maintain the confidentiality of this information. This release may be revoked by me at any time with written notification.

I have been invited to attend the meeting at which services will be discussed.

I have read the above or had it read to me and I understand and agree to what it says.

Client's Printed Name	Client's Signature
Client's Address	Date

Participants

- Liv./ Wyoming ARC
- Chances and Changes, Inc.
- Liv. Co. Department of Social Services
- Liv. Co. Mental Health Services
- Liv. Co. Council on Alcoholism and Substance Abuse
- Liv. Co. Youth Advocacy
- Liv. Co. Office of the Aging
- Center for Dispute Settlement
- Noyes Mental Health
- Liv. Co. Sheriff's Dept.
- DePaul Mental Health Services
- Liv. Co. Family Court
- NYS Office of Mental Health
- Genesee Valley BOCES
- Rochester Psychiatric Center
- Catholic Charities of Livingston County
- Office of Housing/Section 8
- Lakeview Mental Health Services
- VESID
- Liv. Co. Deptartment of Health
- Liv. Co. Office of Workforce Development
- Arbor Development

Please add below any additional agencies to whom information will be released:

_____

_____